Health Plan Assigned Dispute # ____________

Phoenix Health Plan
An Affiliate of Abrazo Health Care

PROVIDER CLAIM DISPUTE FORM

Arizona Revised Statute § 36-2903.01 (B)(4) AND Arizona Administrative Code R9-34-405 state in part:
All claim disputes (i.e. complete or partial denial of a claim) must be submitted in writing within 12 months from the date of service (or the date of discharge for an inpatient claim) or within 60 days of the last adverse action, whichever is greater.

Claim Dispute requests must include:

1. A completed Claim Dispute Form **OR** a letter detailing the factual and legal basis for your dispute (please use one form for each disputed claim);
2. A copy of original claim and remittance advice;
3. Disputes with a clinical component (such as denied inpatient days, services denied for lack of medical necessity, claims denied for lack of prior authorization, etc.) should include a narrative describing the relief requested and all relevant medical records:
4. Mail the completed form(s) and documentation to:

Claim Disputes
Phoenix Health Plan
7878 N. 16th St. #105
Phoenix, AZ 85020

Your dispute will be acknowledged within five (5) working days. You will receive a written Notice of Claim Dispute Resolution explaining our decision within thirty (30) calendar days. PHP may request an extension of up to fourteen (14) additional days if necessary. Payment for approved disputes will also be displayed on the remittance advice. If you disagree with our resolution, you may request a hearing as per the guidelines in A.A.C. R9-22-405(D) or as indicated on the Notice of Claim Dispute Resolution.

NOTE:
Disputes that fail to detail the facts of the case as well as the legal argument OR disputes submitted with incomplete information may be denied without further review. PHP will not attempt to solicit supporting documentation.

Provider Information:

Date:	Provider / Group Requesting Review:
Contact Name (First Name, Last Name):	Department:
Correspondence Address:	
Fax Number:	Phone Number:

Member Information:

Member Name:	Date of Birth:	AHCCCS I.D.:

Claim Information:

Claim / Form #:				Date of Service:		
Procedure Code(s) disputed:						

Reason/Supporting Information for Reconsideration Clinical Documentation Attached ☐Yes ☐No